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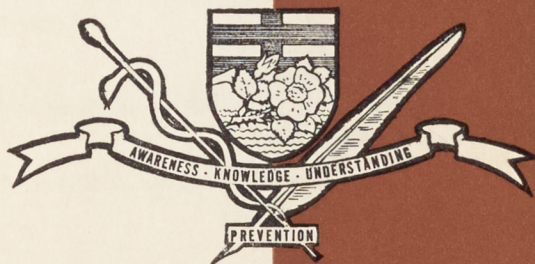
VOLUME 1 NUMBER 1

JUNE, 1962

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- The Lonely Road
- Willingness to Invest
- AA as a Community Resource
- Medical—A New Drug in the Treatment of Alcohol Withdrawal
- Foundation Activities



THE ALCOHOLISM FOUNDATION OF ALBERTA

The Alcoholism Foundation Of Alberta

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Telephone GArden 4-7161

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PROGRESS

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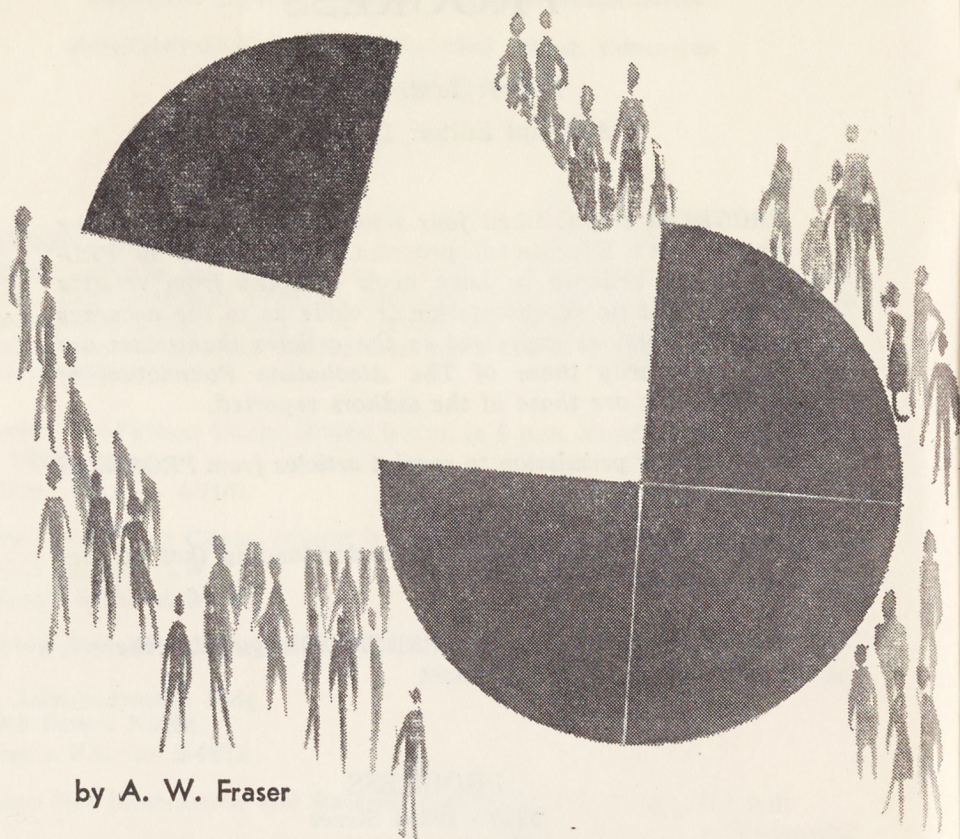
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SOCIAL DRINKER? or



by A. W. Fraser

Social Drinkers

AS CLOSELY as can be determined, 75% of all adult Canadians drink alcoholic beverages to some extent. This 75% can be divided into three approximate groups:

1. Occasional drinkers*
2. Fairly frequent drinkers
3. Very frequent drinkers

Occasional drinkers are those who have a drink now and again, usually on some special occasion.

They seldom have more than one drink, and rarely get intoxicated*.

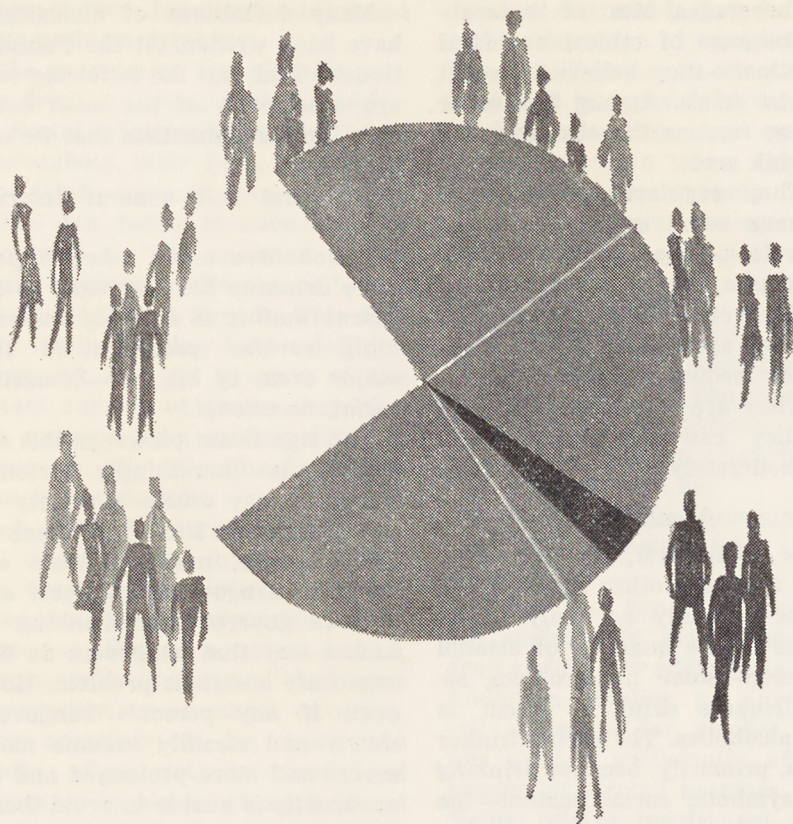
Fairly frequent drinkers are probably the largest group. They drink on many social occasions, and may or may not keep a supply of liquor in the house. They may occasionally get intoxicated, but seldom drunk*.

*Definitions of terms used in this paper:
'Drinker'—any person who ingests alcoholic beverages whether occasionally or regularly.

'Intoxicated' — mild intoxication. Under 0.1% blood alcohol concentration.

'Drunk'—over 0.1% blood alcohol concentration.

ALCOHOLIC?



Very frequent drinkers are those who use alcohol almost daily (regardless of the amount) or drink heavily on weekends. Some of these may frequently become intoxicated.

Another smaller group within the very frequent drinker group are the 'irresponsible drinkers.' These drink, usually, with the definite intention of getting drunk, and they don't care where they get drunk or what other people think about it. They don't abide by the social rules that govern for most

people the where, when, and how much of drinking. If they *choose* to drink only a little, they can do so, but they usually choose to do a thorough job of it. Their drinking seldom interferes too seriously with their work performance, but does damage their domestic and social life.

About 3% of this total group of drinkers (the 75%) develop the condition called alcoholism.

Abstainers

Approximately 25% of adult Canadians do not drink any alco-

holic beverages. Most of these abstain because of ethical or moral convictions—they believe it is not right to drink. Among the other common reasons the abstainers do not drink are:

1. They regularly get sick or have some unusual and unwelcome reaction to alcohol—nausea, severe headaches, etc.
2. They cannot afford to drink;
3. They are advised not to drink for medical reasons;
4. They are alcoholic and know they can no longer drink moderately.

Alcoholics

How do the 3%, the alcoholics, differ from the other drinkers?

It is certainly not only a difference in the quantity of alcohol consumed—some non-problem, social drinkers drink as much as some alcoholics. The social drinker drinks, primarily, because drinking is a symbolic social custom—the pharmacologic properties of alcohol are of secondary importance. The alcoholic, however, drinks **for** these pharmacologic effects — he uses alcohol as a drug, not as a social lubricant. Anyone who misconceives the alcoholic's drinking as differing only in quantity from that of the social drinker will find it impossible to understand why the alcoholic has such difficulty in quitting or at least in using alcohol as social drinkers do. The social drinker's drinking is a social act; the alcoholic's is the ingestion of a drug.

Many definitions of alcoholism have been written. At the Foundation we find that the following two are descriptive of the most common type of alcoholism that we encounter.

The first is a general description:

'Alcoholism exists when a person's drinking has increased to an extent that it is creating increasingly serious problems in the major areas of his life—domestic, social, vocational.'

The significant phrase in this definition is 'increasingly serious.' Drinking may create a variety of problems in the life of any drinker. For example, many drinkers experience hangovers. But most are able to govern their drinking in such a way that hangovers do not constitute a serious problem. However, if any person's hangovers slowly and steadily become more severe and more prolonged and he apparently is unable to avoid them, it is probably a sign of alcoholism. Similarly with problems of a domestic, social, and vocational nature caused by drinking. If these are temporary or static they cannot be considered an indication of alcoholism; but if they become increasingly serious, and the person is unable to recognize the role his drinking plays in creating them or if while recognizing the connection is unable or unwilling to stop or reduce his drinking, he undoubtedly has alcoholism.

The second description emphasizes the main differentiating

characteristic between problem and non-problem drinking:

'The progressive loss of ability to drink according to intention'

Social drinkers have, and retain throughout their lives, the ability to drink according to intention. They can decide to have 'a drink or two,' to 'kill an hour in the pub,' perhaps to 'tie one on,'—and this is just what they do. This does not imply that they have a definite, clear-cut idea in advance of the exact number of drinks they plan to consume on a specific drinking occasion; the intention is usually much less definite.

A social drinker may occasionally misjudge and 'overshoot,' that is, become more intoxicated than was intended or appropriate to the occasion. But, if a person begins, occasionally at first and then more frequently, to overshoot on drinking occasions; if he, more and more often, gets intoxicated at times or in places where it is not to his personal advantage to do so, then he is not doing this because he intends to or wants to. He is doing it because he cannot prevent himself; he has developed alcoholism.

The progressive loss of ability to control the quantity of consumption is the outstanding characteristic of alcoholism. It must be appreciated that 'will power' or 'conscious determination' is not effective in maintaining or re-establishing the alcoholic's ability to control the quantity of consumption. Whatever factors are involved in

this loss of control, they do not lie within the scope of conscious will. Use of will-power is effective and important in refusing to drink any alcoholic beverage, but once the alcohol has been taken, this reaction, which the alcoholic experiences as a demand for more alcohol, may occur.

Kinds of Alcoholism

Although several kinds of alcoholism have been identified, our concern is with the two most common disease or addiction types seen in Anglo-Saxon countries. We can refer to these as:

1. Bender type alcoholism;
2. Daily excessive type alcoholism.

These two types of alcoholics are addicted to alcohol much as drug addicts are addicted to drugs. Addiction implies an increasing cell tolerance for alcohol. What was once a sufficiently effective amount of alcohol becomes, as addiction sets in, insufficient, and so the addict experiences a craving for more alcohol. When he tries to cut down or stop drinking, he must be prepared for a period of acute discomfort, identical to the discomfort experienced by persons withdrawing from or breaking a narcotic addiction.

Bender Type

A bender type alcoholic loses his ability to control how much he drinks once he starts drinking. He is able to quit drinking, that is to abstain completely, for periods of days, weeks, or even months, but

when drinking starts he will often drink more and get drunker than intended. In the later stages of alcoholism, his benders or excessive drinking sprees will last for a week or more, during which he neglects almost completely all responsibilities and is obviously drunk much of the time. During the middle stages the benders are shorter—two or three days, occurring most often, but not always, on weekends and then extending into Mondays. In the early stages, the bender type alcoholic is hard to recognize. He often appears an enthusiastic one-night drinker. His alcoholism is indicated by his drinking more and getting slightly more intoxicated than the rest of the party. He wishes to keep on drinking when the others are ready to call it a day.

Bender type alcoholism, then, is characterized by the progressive loss of control over how much one drinks, once drinking starts.

Daily Excessive Type Alcoholism

The daily excessive alcoholic gradually increases his daily consumption of alcohol, but he does not often become grossly intoxicated. In the early stages his drinking is confined largely to the evenings. As his illness progresses, he will drink after work, then at noon hour, then in the morning, and then throughout the day. He maintains a certain concentration of alcohol in his system at all times and when the concentration drops below a certain level, he will feel

uncomfortable and tense. As the years go by, a higher and higher concentration is required to maintain a feeling of comfort. The daily excessive alcoholic cannot abstain without enduring a period of intense discomfort—withdrawal—nor can he reduce the amount he drinks daily for any length of time. If he tries, he will be able to do so only temporarily, then his daily consumption will build back up and eventually surpass the previous level.

During the early stages, the daily excessive alcoholic is difficult to distinguish from the excessive non-problem drinker. Even in the middle stages his condition is not too obvious to those who do not have special knowledge about alcoholism. He is seldom obviously intoxicated at work or during the day, although he may drink to intoxication at parties or late in the evening. He keeps hidden from others the fact that he does require regular booster shots of alcohol to keep him going. When daily excessive alcoholics reach the bottle (25 ounces) a day level, they suffer much reduced job efficiency. Although still not appearing intoxicated, they are so dulled by mid-afternoon that they are capable of handling only routine activities.

These then are the two disease types of alcoholism most frequently encountered in North America. During the very early stages and the very late stages, they are not too easily distinguished one from the other, but in the middle

stages, the drinking patterns are quite different and easily recognized.

Major Characteristics of Alcoholism

Alcoholism has three major characteristics:

1. It is progressive,
2. It is chronic,
3. The alcoholic is usually unable to recognize that he or she is alcoholic.

Progressive

A progressive illness is one that slowly becomes more serious unless treated. Many illnesses have this characteristic — diabetes and cancer, for example. If these illnesses progress unchecked, the result is a continuous deterioration of the afflicted person's health and abilities and a shortened life span. Successful treatment checks the progress of the illness and results in recovery from many of its effects.

Alcoholism is most certainly a progressive illness. In the early stages its symptoms are not too pronounced nor is its effect on the alcoholic's life too obvious. Both the symptoms and the effects become more and more obvious as the condition progresses.

Chronic

A chronic illness is one which is permanent or of very long duration. Once a person has developed alcoholism, the condition is per-

manent. That is, he will for the rest of his life be unable to drink moderately and any attempt to be a controlled social drinker will inevitably lead to excessive drinking. Although an alcoholic may recover from some of the effects of his illness by not using alcohol, he does not regain his ability to control the quantity of his consumption. Whatever change has taken place to cause this abnormal reaction to alcohol, it is of a permanent nature. Why this is so cannot yet be explained, but there is ample evidence in the many examples of alcoholics who, after a period of sobriety, sometimes years of sobriety, have again attempted to be social drinkers. For a while they may appear to be controlling the amount they drink, but before long their alcoholism becomes active and their drinking becomes increasingly excessive.

Inability to Recognize Their Alcoholism

The alcoholic has great difficulty in recognizing and accepting the fact that he is alcoholic. His alcoholism may be most apparent to his family and friends, but he cannot see that his many serious problems and difficulties are caused by the way he drinks. He feels that his excessive drinking and frequent drunkenness are attributable to his problems and that if these were cleared up, he would be able to control his drinking. He strongly resents any suggestion that he is alcoholic.

Who Becomes Alcoholic?

Anyone who drinks may become alcoholic. There is no way of telling in advance who may be one of the 3% of drinkers who develop this condition. Alcoholism, like most other illnesses, affects a cross-section of the population.

The causes are not known. It is generally believed that certain individual people are predisposed to become alcoholic. But, whether this predisposition is of a physical, psychological, or socio-cultural nature, or any combination of these, is not known. Many theories as to the cause or causes of alcoholism have been proposed, but as yet none of these have been sufficiently verified to be widely accepted.

At the present time, therefore, it is impossible to predict who will become alcoholic. A good deal is known about the nature, development and effect alcoholism has on the lives of those who develop it. It has also been demonstrated by thousands of alcoholics that remarkable recovery from the effects of this illness is possible, as long as the alcoholic will give up drinking completely, and not try again to be a social or moderate drinker.

How Common is this Illness?

In Canada about 3% of those who drink will sooner or later develop a serious drinking problem. This is a small percentage of the total number of drinkers, but when this percentage is translated into numbers it represents a very large group of people; in excess of 200,000 in Canada, about 12,000 in Alberta. The prevalence of alcoholism varies from country to country. Some are higher and some are lower than Canada. In the United States about 6% of drinkers develop this illness, whereas, for example, in Italy, the percentage is considerably lower.

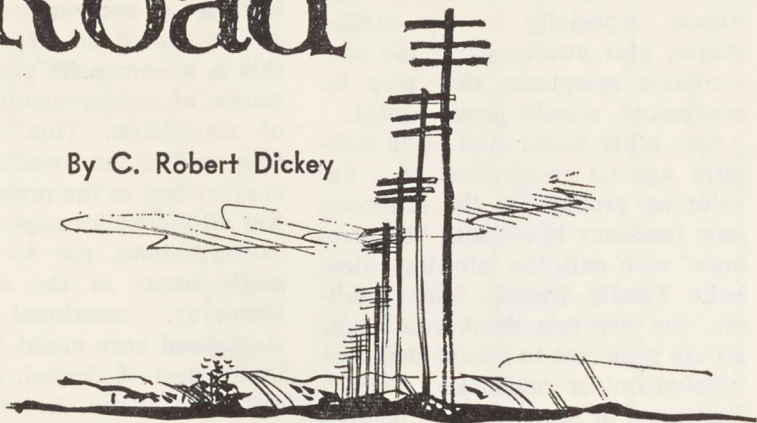
Although, in speaking of alcoholism and alcoholics, we usually use 'he,' this does not mean that only men develop this condition. It is not as prevalent among women, but still a good number do become alcoholic. In Canada it is estimated that one out of every five or six alcoholics is a woman.

Alcoholism is one of the most serious public health problems in North America and endangers the lives of millions of persons who do not recognize that they have this illness or, recognizing it, do not understand that for them total abstinence for life is necessary.

Mr. A. W. Fraser is Associate Director, Treatment Services at The Alcoholism Foundation of Alberta.

The Lonely Road

By C. Robert Dickey



Alcoholics have been described as the loneliest people in the world. This article deals with some of the signposts along their lonely road.

MEDICAL recognition of a disease or illness, generally speaking, requires that the illness have a characteristic train of symptoms and follow a reasonably predictable course. The species of alcoholism that is predominant in North America fulfills these requirements.

It is proposed here to discuss that train of symptoms and that

course. But, first, some general observations.

Most people who are in close contact with an active alcoholic are baffled by his behavior. They fail to realize that this is not an isolated case, but is, rather, typical of the vast majority of the estimated 5,000,000 alcoholics on this continent.

These symptoms of an authentic

illness are most frequently thought to be the deliberate behavior of a deviant person whose illness (if indeed it is admitted to be an illness) is self-inflicted, deliberately and stubbornly pursued with a singleness of purpose that is utterly incomprehensible to the observer. The alcoholic appears to flout the laws of God and man, to invite ignominy, and to court disaster. Some knowledge of the characteristics and phases of the illness, especially in the earlier stages, plus awareness of the pre-alcoholic symptoms that may be recognized, should prove useful.

One other factor that often militates against recognition of a developing problem is the still-common tendency to identify 'the alcoholic' with only the late-stage alcoholic. Family, friends, fellow-workers, the problem drinker himself, all are reluctant to accept the label 'alcoholism' or 'alcoholic.' This is analogous to repudiating a diagnosis of tuberculosis unless the patient is far advanced, highly infectious, with cavities, and an almost hopeless prognosis; or a diagnosis of cancer if the patient has not reached the terminal stage.

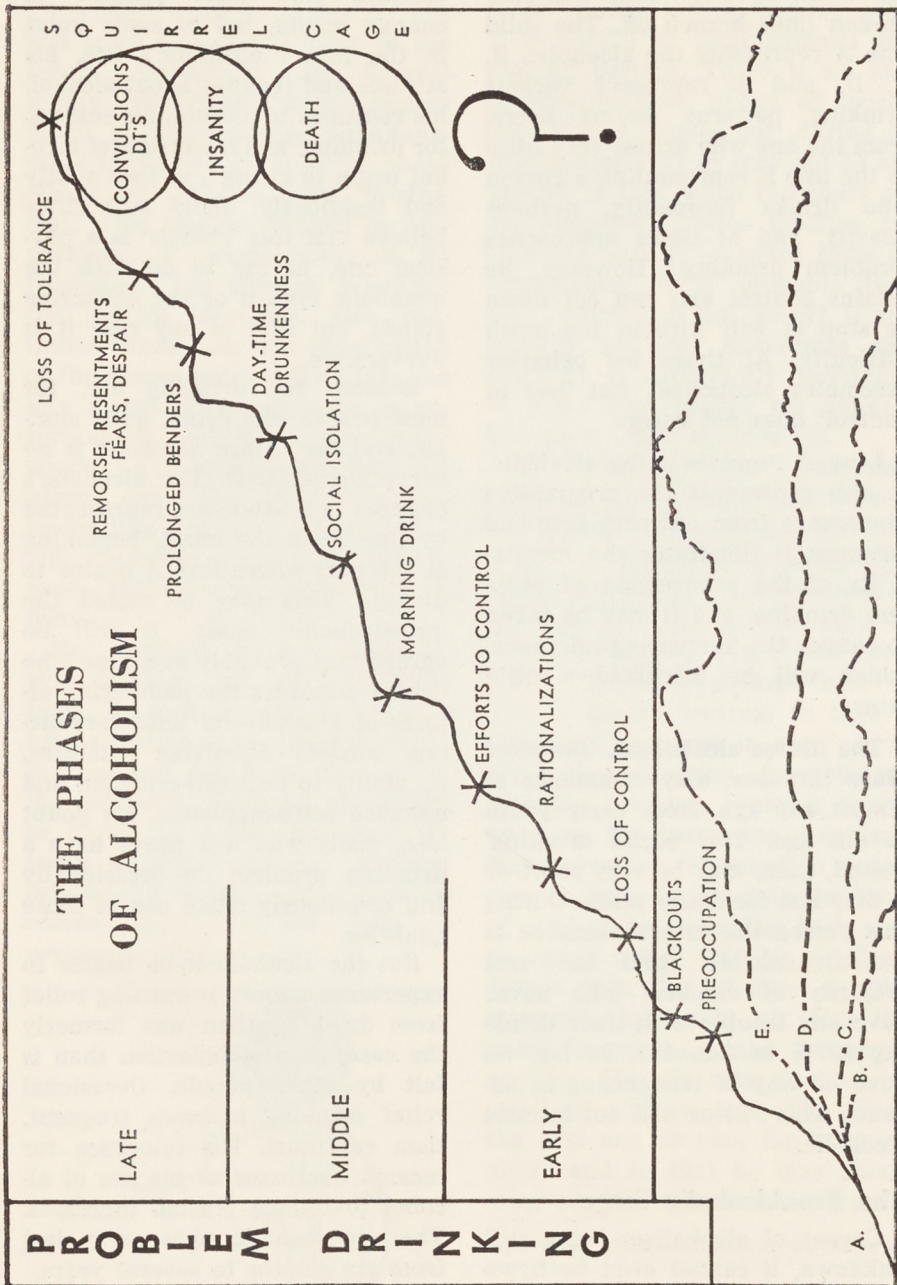
It is a fact, however, that the majority of alcoholics in our Canadian society are in early or middle stages, and present a picture of relative stability, since their ailment is still largely hidden. Alcoholism lends itself to concealment, and often for many years the family, friends, and fellow-employees cooperate to protect and 'cover-up'

for the alcoholic in the mistaken belief that they are helping. Earlier recognition of warning signals by family or friends, or by the problem drinker himself, may prevent many years of mounting torture or untimely death.

IN THIS paper we draw heavily on Dr. E. M. Jellinek's 'Phases of Alcohol Addiction in Males,' which is based on a comprehensive study of several thousand case histories of recovered alcoholics in AA. It should be pointed out that this is a 'composite picture' of the course of our predominant variety of alcoholism. This species has been called the 'bender' type and is described in the previous article. Not all alcoholics experience all of the symptoms, nor do they necessarily occur in the same order. Moreover, occasional symptoms mentioned here might be observed in any user of alcohol, with no special significance. However, a cluster of symptoms, three or four perhaps, occurring again and again, can be considered indicative of a problem, present or developing. (It may be noted that, though this study applies more especially to the 'bender' species of alcoholic, many of the symptoms here described apply also to the 'daily excessive' type of alcoholism.)

The Chart

Since most alcoholics probably began as 'social drinkers,' Chart I shows a line commencing at the lower left corner, the first part of which represents the 'social drink-



ing' common to all; from this four broken lines branch off. The solid line A represents the alcoholic. B, C, D, and E represent various drinking patterns among users, from the one who drinks very little to the line E representing a person who drinks frequently, perhaps heavily, and at times approaches 'problem drinking.' However, he retains control and can cut down or stop at will without too much difficulty. At times his behavior resembles alcoholism, but 'loss of control' does not occur.

Line A represents the alcoholic. It also represents the progressive divergence from ordinary drinking customs; it illustrates the inevitability of the progression of problem drinking, and it may be taken to convey the 'increasing tolerance' which will be discussed a little later.

The illness alcoholism, like most other illnesses, may commence at almost any age, from early youth to old age. The 'social drinking' period, then, may be very short or it may last for many years. During this period the future alcoholic is indistinguishable from the vast majority of drinkers who never have any trouble with their drinking (97% in Canada). So far, we have no way of recognizing in advance who will or will not become alcoholic.

The Pre-Alcoholic Stage

Causes of alcoholism being still unknown, it cannot even be hypo-

thesized just what process of change occurs, but at some point in the future alcoholic's life, his attitude and feelings about alcohol, his reactions to alcohol, his reasons for drinking, and his intake of alcohol begin to change, at first subtly and insidiously. Many authorities believe that this 'change' is a physical one, having to do with the metabolic system or the endocrine glands, but that in any case it is irreversible.

Reasons for drinking are, for most people who drink, quite similar, and the future alcoholic is no exception, at first. The alcoholic's changes in attitude are represented by line A on the chart, beginning at the part where line A begins to diverge. This may be called the 'pre-alcoholic' phase. It will be agreed that probably everyone who drinks discovers the pampering effects of alcohol—its tension-reducing, anxiety-dissolving qualities, its ability to dull self-criticism and enhance self-acceptance. No doubt also, many who will never have a drinking problem do occasionally and consciously make use of these qualities.

But the alcoholic-to-be begins to experience a more rewarding relief from drinking than was formerly the case, more satisfaction than is felt by other people. Occasional relief drinking becomes frequent, then continual. His tolerance for tension decreases as his use of alcohol to reduce tension increases. The pre-alcoholic phase may last from six months to several years.

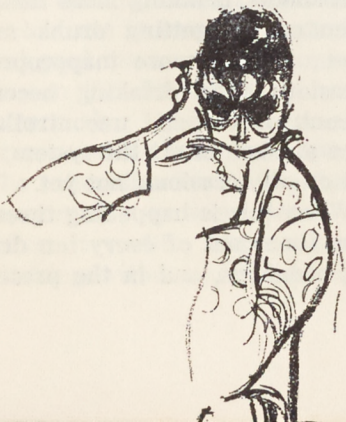
Prodromal Phase

Alcohol comes to occupy a more and more meaningful place in the future alcoholic's life. Several highly significant developments begin to occur almost simultaneously at the beginning of the phase which Dr. Jellinek calls 'prodromal.' This may be defined as preparatory, or premonitory, or introductory. His physical tolerance for alcohol increases. This continues throughout the progression of the illness until well on into the late stages. This symptom is unfortunately mistaken by many people for a 'good' sign: that this person can 'take it,' or 'hold his liquor like a man.' Heavier drinking naturally follows, since he needs more to gain the same effects.

He develops a *preoccupation** with drinking and drinking situations. He seeks to repeat and prolong situations that have been enjoyable and satisfying because of the incidental drinking. He begins to think of social occasions in terms of this incidental drinking rather than of the social activity involved. He may by now have experienced his first *blackout*.

The blackout, or blank-out, is not to be confused with 'passing out.' It is partial or total amnesia for varying periods. There is no loss of consciousness, unless of course the drinker 'passes out' during it. Intoxication may or may not be apparent; in fact, when blackouts occur repeatedly, after medium intake and with no outward signs of intoxication, it is probable that true addiction is not far off, if not actually present. Sometimes the blackout is sufficiently terrifying to make him realize his danger, but more often he goes on.

Throughout the prodromal phase, the preoccupation referred to manifests itself in any number of ways. There is a growing concern about supplies, about whether or not there will be enough to drink on this or that social occasion. This may prompt him to 'prime' before leaving, to take a mickey along, 'just in case,' or to sneak the odd drink. Surreptitious drinking becomes common procedure as his increasing tolerance makes greater consumption necessary in order to maintain the level of comfort he seeks. But he is also becoming aware that his drinking differs from that of other people, otherwise he would not feel the need to sneak drinks whenever possible. He will take doubles instead of singles, and gulp down the first one or two, for a 'quick glow,' and so that he may thereafter sip his drinks as others do.



*The words in italics refer to the chart on page 11.



Already he is secretly concerned, feels guilty, and a bit ashamed of being 'different.' He will avoid references to his drinking; whereas he used to brag about how much he could drink, he begins to lie about how much he did drink. Blackouts may become more frequent and are experienced after smaller consumption.

Marital relationships become strained during this phase. Humiliating scenes will not be uncommon, but the wife is eager to accept his expressions of sorrow and his promises to do better. She tries to convince herself that no real problem exists; she feels some concern but no alarm as yet. The prodromal phase may last from six months to five or six years.

Early Phase

Dr. Jellinek places the beginning of addiction at 'loss of control.' This is noted on the chart as the beginning of the early phase, or in Dr. Jellinek's terms, the 'crucial phase.' Many specialists believe that loss of control is merely another step in the process that began much earlier, in the prodromal phase, in fact. Dr. Jellinek himself says, '... it is feasible to intercept incipient alcohol addiction at this stage. ... It goes without saying that even at this stage the only possible modus for this type of drinker is total abstinence.'

The point is, that 'loss of control' does not occur overnight, and that the loss of control here applies only to quantity consumed, once started. At this point, and for a considerable time to come, the alcoholic can abstain for periods extending into months on end, but once having taken alcohol into his system, he has no longer any certainty that he will be able to stop at will. A characteristic of this type of alcoholic is that he gradually loses his power of choice, his ability to drink according to intention. With increasing frequency he over-shoots, drinking more than he intended to, getting drunk more often, and on more inappropriate occasions. The drinking becomes uncontrolled and uncontrollable once alcohol enters the system, but not on all occasions, not yet.

When this is happening three or four times out of every ten drinking occasions, and in the presence

of other confirmatory symptoms, there is no longer any doubt about the diagnosis; addiction has set in. Will-power at this point is not in question. Any drinking of alcohol is apt to start a chain reaction, as yet incompletely understood, which sets up an insistent need for more alcohol, and which increasingly results in more drinking. This has passed beyond the realm of conscious determination.

An outstanding symptom in the early stage is the system of *rationalizations* which spreads progressively to every phase of the alcoholic's life. His drinking behavior is becoming more conspicuous, and is beginning to call forth reproof from his wife, perhaps from his employer. Friends become reluctant to accept his social invitations and to include him in their invitations, because he 'always makes a fool of himself.' His children too feel the social pressures, and withdraw from him because of his unpredictability.

Guilt and remorse haunt him increasingly, and he finds it necessary to construct an elaborate system of excuses and reasons for his heavy drinking. He is able to convince himself on each occasion that he had not in fact lost control, but had good reason to get drunk; that he can 'handle' liquor as well as anyone else, but who wouldn't get drunk under those circumstances? The rationalization system helps to counter the growing social pressures; it enables him to keep on drinking without complete loss of

self-esteem, at least during this phase. He thinks that he is convincing other people with his rationalizations, but primarily they are desperately needed for his own reassurance.

His self-esteem, however, does suffer, and he must compensate, which he does partly through 'grandiose behavior,' tipping lavishly, ordering unnecessary taxicabs,



making pointless long distance calls and the like. Another aspect of the rationalization system is the alcoholic's growing conviction that others are responsible for his problems, not he. Anti-social and aggressive behavior results. This again generates more guilt and more remorse, to be assuaged only by more drinking. The early phase may last from two to ten years.

AS HE NEARS the middle phase, he tries many *methods* to *re-gain control*, or rather as he sees

it, to demonstrate that he has not lost control. He will 'swear off,' or 'go on the wagon' for certain periods. He will determine not to drink before a certain hour, or only at home, or set a limit to the number of drinks in a given period. He will switch from rye to scotch, scotch to wine, wine to beer, and so on. Each time he 'discovers' some new formula he will be convinced that he 'has it licked.' He fears that what his wife and (perhaps) his friends tell him is true, namely that he has no will-power, and it becomes an obsession with him to prove how wrong they are. Rather than fearing that he will get drunk if he takes that first drink, he convinces himself that 'this time it will be different.'

The alcoholic may, at some time during this period, consult his doctor, perhaps at the insistence of his wife, who fears that alcoholism may be developing, and has heard that it is a medical problem. Since the patient tends of course to minimize his drinking and the trouble it is causing, the doctor may assure him that he is not an alcoholic, but since he admits he is drinking too much, he should cut down. In other words, exercise conscious control. This is just what the patient wants to hear, but the prescription is impossible. Control is exactly what he has lost, and this is a permanent loss.

The Middle Phase

Varying degrees of pleasure usually attended his drinking dur-

ing the pre-alcoholic and prodromal phases, and through a portion of the early phase. That period has been called 'pleasure drinking,' as distinguished from the 'sick drinking' that begins as he approaches the middle phase. When he begins to feel the need for an 'eye-opener,' it is for medicinal purposes, to help him 'get along,' to 'start the day right,' to 'settle his nerves.' This need for a medicinal *drink in the morning* marks the beginning of the middle phase.

Most of us have heard that 'alcoholics drink in the morning.' Many problem drinkers are appalled at the mere thought of being an alcoholic, and for a long time they may resist the need for the eye-opener. Some will suffer excruciatingly for months, perhaps even years, rather than accept the label 'alcoholic.' But sooner or



later it becomes impossible to start the day without a drink. For a while, attempts are made to mask the tell-tale odor, with mints, strong mouth-wash, breath-purifiers, and so on.

The earlier symptoms remain with the alcoholic; he takes them with him, so to speak, and they become intensified and more difficult to hide. His tolerance for alcohol continues to increase, requiring greater and more frequent consumption; he over-shoots unintentionally more often, the blackouts continue, the efforts to control the drinking still seem feasible, and occasionally there is the appearance of a measure of success, but after each apparently successful period of abstinence or other control method, he returns to the old pattern, usually in a more pronounced manner. Remorse and resentments go hand in hand. Nobody 'understands' him.

The marital and home situation has been deteriorating. His wife has long since recognized the problem and has tried every method that has been tried by hundreds of thousands of other alcoholics' wives, with no success. She and the children suffer acutely, from *social isolation*, shame, and anxiety. She may order him out, or leave home with the children. If she returns, it will be to take over as head of the family. She will reorganize the (by now) badly disorganized home; the children no longer look to father for authority or love. They all are sure that 'if Daddy loved



us, he wouldn't act this way.' His whole personality has been undergoing changes for the worse that are reflected in such comments as: 'he seems like a different person,' or 'he isn't the man I married.'

His hostility increases to the point where he anticipates rejection by friends whom he has humiliated or insulted, and he will drop friends who have tried to help him. He will anticipate discharge from his employment, quitting just before the fall of the axe. As his life becomes more and more alcohol-centred, the 'reasons' and excuses for drinking multiply; his concern becomes 'how his activi-



ties will interfere with drinking,' rather than how his drinking will interfere with his activities; and all outside interests suffer. He reinterprets all his inter-personal relationships in the light of his decreasing interest in anything but alcohol; his egocentricity leads to more isolation, more rationalizations and mounting self-pity. Many alcoholics at about this time try the 'geographic escape.' Having convinced themselves that it is all the fault of environment, or the job, or the home and family, they will try to make a new start somewhere else. Of course this never has the desired result.

From the first eye-opener to occasional, then regular, morning drinks, then to several more in order to keep going, it is a short step to occasional *day-time drunkenness*, which will mark the period

PROGRESS

when the middle stage merges into the late stage. His resentments become more and more unreasonable. In the past it has not been too difficult to find new jobs, but now jobs become harder to find and harder to keep. There seems to be a conspiracy directed toward 'keeping him down.'

The Late Phase

The middle phase may last from two years to seven or eight. It is difficult to discern the beginning of the late phase, but he has certainly reached it when his *benders become prolonged*, where formerly they were for the most part confined to evenings and then long weekends. It has been noted that the early stage has been called 'pleasure' drinking, and the middle stage 'sick drinking.' The late stage has been referred to as 'disaster drinking.' This it certainly is, but usually disaster, in a variety of forms, has already struck.

Protecting his supplies has been a major concern through many years, but now it becomes obsessional, senseless. He lays in large stocks of liquor and hides bottles in the most unheard-of places. A picture of the utmost in frustration is the man who has hidden a bottle on Saturday night in a blackout, who needs a drink desperately Sunday morning, but cannot remember where he has hidden the medicine.

Steadily increasing consumption of liquor has caused increasing neglect of proper nutrition, and

many alcoholics suffer from this neglect. Hospitalization may now become necessary for any one of a variety of complaints caused or aggravated by nutritional deficiencies.

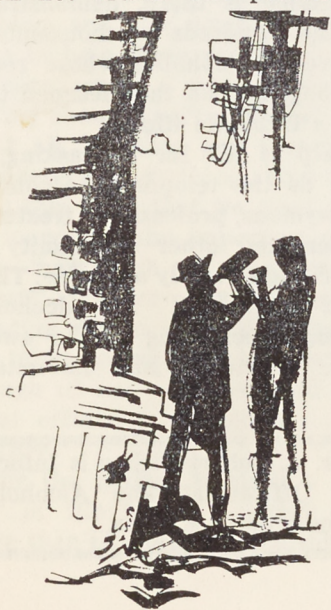
THROUGHOUT THE early and middle phases most alcoholics exposed themselves, apparently wilfully, to grave risks: loss of home, job, prestige, everything. Though this may seem paradoxical, they were at the same time exerting prodigious efforts to cling to some social footing and some self-respect. But by this time, rejection on all sides is so obvious that the alcoholic begins to believe that he is in fact without merit and without hope, though sporadically he may try for control. Ethically and morally he deteriorates; his thinking becomes impaired, even when not drunk. The personality

changes mentioned earlier are by now pronounced and unmistakable.

He will become indifferent to the kind of alcoholic beverage he drinks, and may even have recourse to commercial products like rubbing alcohol, extracts, or after-shave lotion. He will drink with companions far below his social level, perhaps partly to recapture some feeling of acceptance or superiority.

His *alcohol tolerance*, which started to increase in the prodromal phase, now vanishes. To his dismay, he gets drunk on less than was formerly needed just to get a glow on. Anxiety has long been ever-present with him, but now it is a palpable thing. He 'feels everything closing in on him.' He is prey to nameless, indefinable fears, a sense of impending doom. He may hear voices, threatening, accusing, decrying him; he is filled with raging *resentments* and jealousies. Only one thing will give him some temporary relief from the torture of the 'squirrel-cage'; more alcohol and oblivion. He is sick from drinking; he drinks because he is sick; he drinks to ease or escape from the problems created by drinking.

Intolerable *remorse* and guilt are with him constantly; only liquor will ease the pain. Uncontrollable tremors beset him most of the time, but can be to some extent reduced by more liquor. He may have convulsions or 'rum fits.' *Delirium tremens* may occur; this is an intense though transitory psychosis. More chronic psychoses





may develop if the drinking continues.

At this point he has been described as 'infantile, regressed, neurotic, selfish, irresponsible. He appears to be apprehensive, anxious, jittery, bleary-eyed, sloppy, untruthful, undependable; suggestible and easily swayed one moment; perverse, belligerent, and stubborn the next. When his drinking has reached the point where he has the 'shakes' he is a pathetic and perspiring mass of tremors and jerks, with a sullen and painful expression, with an untidiness and dissipation that are characteristic.'

Skid Road or the mental hospital may be the destination of many of those who reach this stage. But comparatively few alcoholics do reach this late late stage; most do not live long enough.

Recovery Through Treatment

At one time it was thought, and to this day there are some who still think, that the alcoholic must 'hit low bottom' before he is 'ready' for recovery. They tell us that in the old days of AA a man who had not gone completely under, who still held on to some shreds of respectability, was told to go away and do some more drinking because 'he hadn't suffered enough.' We know now that this view of the recovery potential in alcoholism is defeatist, and unfounded; it may lead to tragedy.

Many late-stage alcoholics make remarkable recoveries, but recovery can commence at any point along the road, provided that the alcoholic recognizes his ailment and his inability to recover by his own unaided efforts. He must surrender, but he must have hope. The hope is there, demonstrated by the hundreds of thousands of recovered alcoholics whose recovery began when they learned they had a treatable illness.

Help is his for the asking, as near as the telephone. Alcoholics Anonymous, professional treatment clinics, and other community resources are readily available. There is a 'new deal' for alcoholics, through increasing public awareness, knowledge, and understanding.

Mr. C. Robert Dickey is Information Officer at The Alcoholism Foundation of Alberta.

Willingness To Invest

By Vernelle Fox, M.D.

HOW MUCH are you prepared to invest? This sounds like a question posed by a broker, not a physician—but as a physician I would like to pose this question to two groups of people—alcoholics and those interested in ‘doing something about’ the alcoholic.

Patients constantly state that they want to stop drinking; that they want more out of life than they now get; that they want the people to understand and help them. Most of us who are involved with alcoholics, either personally or in business, or just as civic minded citizens, talk and write a lot about the seriousness of the problem and how much should be done to help these patients.

There comes a time when just talking about it isn’t sufficient. We must all, patients and interested outsiders, do something about it. It is at this point that we must each ask ourselves the important question—‘how much are we willing to invest?’ It’s not easy to answer. Wanting things to be different is one thing—being willing to put out enough of our own sustained personal efforts to accomplish it is another.

For the patient wanting a new way of life means a great deal more than to merely stop drinking.

Although this is an essential first step, it is only a first step. Frequently the steps that follow are even more difficult and frightening. When the drinking stops, the process of building a new way of life starts. This can be tremendously difficult and requires years of constant effort. He must be willing to stand all the pain and discomfort for which he previously found relief in alcohol. He must get close to people—get to know them and really let them know him. This can be terribly frightening—they may not like him—they may reject him—they may even try to harm him—all this he must risk.

He must also be willing to assume the responsibility for all his actions. He can no longer blame alcohol for his hostile or anti-social feelings and actions. It may also mean that some people don’t like him as well when he’s honestly sober as they did when he was drinking. And what about the rest of us who say that we can’t help the alcoholic get well—do we mean that we want to help him or do we really mean that we want him to stop drinking.

We expect him to give up alcohol and to be willing to do all these things in order not to fall back on it, but what are we willing

to give in return? Are we willing to stand by him while he undergoes the temporarily crippling process of changing? Will we still accept him when he allows us to really see the resentment and hostility he feels toward us—without our being able to pretend it's not there because he was drinking when he said it? Are we willing, in turn, to let him get close to us and to really know us? Are we ready to stop blaming everything that goes wrong between us on the fact that he drinks?

THIS IS asking a lot on either side, and people are not always willing to give that much. All too often when a patient says he wants to stay sober, he really means that he wants to stay out of trouble; not get sick; not have people mad at him; but he doesn't mean that he's willing to stop drinking or stop using alcohol as

a means of controlling his personal discomfort or the actions of the people around him.

On the other hand, those of us involved with the alcoholic say that we want to help him. Do we mean that *we* want to help *him*, or do we really mean that we want him to stop drinking and to conform to our standards? It is quite convenient to assume that his drinking is causing him as much difficulty as it is us and that to stop is a very simple matter if he just would. We are not always willing to recognize that we're asking a lot of him and are not always willing to give a lot in return.

There's an old song: 'It Takes Two To Tango'—frequently paraphrased: 'It Takes Two to Tangle.' I would add: 'It Takes Two Together.' Unless we are all willing to invest a great deal of ourselves, it is not likely that we'll get anywhere in solving the problem of alcoholism.

From *The New Life*, January 15,
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ALCOHOLICS ANONYMOUS

Alcoholics Anonymous As a Community Resource

—by John Park Lee

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.—AA Preamble.

ALCOHOLISM is known to social work today as one of the most complex and baffling problems the worker faces as he attempts to help families solve their problems. Few are the social workers who have not heard of Alcoholics Anonymous and its great success in enabling tens of thousands of alcoholic men and women to win their way back to sobriety. Many have been curious to know how this group has succeeded when so many other individuals and groups have failed; to learn more about its workings; and finally, to discover how they can relate to Alcoholics Anonymous for the benefit of their clients.

Any social worker who is contemplating working with AA, as it is commonly known, would do well to read very carefully the statement that appears at the head of this article. This is AA as the mem-

bers see themselves. This is a description of Alcoholics Anonymous which is read at the opening of virtually every AA group meeting around the world. If the social worker who wishes to work with Alcoholics Anonymous will take the time to study the statement carefully, he can avoid many of the difficulties that are encountered in working with AA and have a better chance of securing the help of this fellowship for his client.

First of all, as the statement says, Alcoholics Anonymous is a fellowship. This is probably the best word that could be chosen to describe this unique group of men and women. It is not an organization in the commonly accepted sense of the word, with structure, by-laws, officers, directors, executives, and so on. It is not an agency in any sense; AA members

would strenuously resist being described as a welfare agency. It is not, of course, a church, although as we shall see later it has a deeply spiritual basis.

He should also note that the only qualification for membership is a desire to stop drinking. AA has none of the problems of membership present in other groups. There is no formal sponsorship, no admission committee, no potential blackball, no fees or dues for membership. Rather, if the alcoholic expresses any interest at all in maintaining sobriety, he is entirely welcome from that moment on.

One of the 'Twelve Traditions' of the AA movement reads as follows: 'An AA group ought never to endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.'

This does not mean that AA is hostile to social work, or to churches or hospitals or doctors or psychiatry, or to any person. AA members have had difficult experiences with many of these agencies and groups and have their personal views about them, but the movement as a whole is not opposed to or in favor of anybody else—rather, it is glad of the interest and concern of any other group for the welfare of alcoholics. AA people work very closely and successfully with doctors, psychiatrists, clinics, hospitals, church groups, and others in helping alcoholics. There is no reason why a similar

effective relationship cannot be established with a social worker in behalf of any client.

Basic Needs of An Alcoholic

There have been considerable discussion and speculation as to why AA has been able to succeed in helping alcoholics while other methods have been so lamentably ineffective. Various people have various explanations. This writer's is that it succeeds because it meets the basic needs of the alcoholic at the time he is confronted with the AA program.

1. The first thing the alcoholic needs is hope—hope that he can recover. No social worker who fears that alcoholics cannot recover can be of any assistance whatsoever to an alcoholic. No matter what the worker says, the alcoholic will sense his lack of hope and react to it. The alcoholic has heard for years from all sources—from his family, his friends; from doctors, nurses, and hospitals; sometimes from ministers and priests, sometimes from social workers—the word that he is 'hopeless.' As he hears this day in and day out, week in and week out, he comes to believe it himself. As long as the alcoholic believes he is hopeless, any program of recovery is bound to fail

By merely introducing him to a group of recovered alcoholics, Alcoholics Anonymous automatically restores hope to him. As he looks at the AA group, he consciously or subconsciously says to himself, 'If

they can do it, I can.' Hence, in the very first contact with this group one of the alcoholic's basic needs—hope—is met.

2. The second need is to be received back as a member of the human race. The alcoholic's experience during his days of acute alcoholism is that of universal rejection. His life is a succession of closing doors. His friends' houses are closed to him because his behavior is such that they can no longer tolerate having him around. The doors of employment slam in his face and may be actually bolted against him through a black-list. It may seem that the doors of his church are shut against him, and he has known for some time that entrance to most hospitals is firmly barred. Finally—and this is most tragic of all—the doors of his own home may be closed to him. Sometimes it seems that the only remaining open door is that of the jail or the mental institution, and this is closed and locked behind him when he is forcibly thrust in.

Here again, from the first contact when he is welcomed with open arms by the members of AA, the alcoholic feels that he is back in the human race again, no longer an outcast. No one asks him where he has been; no one asks him if he is sorry; no one suggests that he ought to be ashamed of himself; nobody points a finger of scorn. Rather, he is asked if he wants to do something about his drinking, and is told that he is entirely welcome. He learns that he has as

much status from the day he joins the AA movement as those who have been in it for perhaps fifteen or twenty years. The value of this acceptance is incalculable; it is one of the tremendous supports AA provides for its new members.

3. The alcoholic needs to accept his alcoholism. It is difficult for the non-alcoholic to believe that alcoholics cannot clearly see that drinking is the cause of their difficulty. The alcoholic, given perhaps even more to rationalization than the average person, points to explanations outside himself for his drinking. He will tell you that he got drunk because he was tired, or sick. He will tell you that he got drunk because his mother-in-law came to town, or because she left; that he drank because he was given a raise, or was fired; that he drank too much because the Democrats won, or because the Republicans won.

All these reasons that seem good to him are, of course, totally spurious. He is drinking because this is the nature of alcoholism; the alcoholic drinks in an uncontrolled fashion, and the fact that he cannot control it is evidence of his sickness. AA again fulfills a real need by confronting the alcoholic bluntly with the nature of his problem. The members brush aside his explanations of why he drinks and tell him that he is drinking because he is an alcoholic and cannot help himself. They tell him that, until he accepts this fact about himself, he is powerless over alco-

hol—that his life has become unmanageable and he will be unable to recover. Here again is an enormously important step in the therapeutic process which AA has discovered: that without this recognition of the nature of the problem, the person who suffers from it will never be able to come to grips with it.

4. AA also fulfills another need of the alcoholic, which is to accept himself as a human being. Alcoholics are apt to be rather Utopian in their concepts. In their immaturity, they have felt that people could be perfect and, finding that neither they nor others have been perfect, have become cynical and disillusioned. Without consciously doing so, AA shows the new members what it means to have strengths and weaknesses, virtues and flaws; to recognize that every day there will be failure and every day perhaps some success.

They show the alcoholic how he can settle for being a human being, accept himself and live with himself and, being able to do so, learn to live with other human beings. AA's talk a great deal of the virtue of tolerance; they learn by association with each other how to tolerate themselves and, being able to tolerate themselves, are then able to get along much better with others.

Spiritual Help

While all these processes are going on—they do not occur, of course, in the chronological order

presented here—the AA novice is also being introduced to the basic source of AA strength: the relationship with God as the members understand Him. It was noted in quoting from the Preamble that AA is not related to any religious sect, and this is true. On the other hand, virtually any member of Alcoholics Anonymous to whom the social worker talks will state that the basis of recovery depends on the ability to relate to a 'Higher Power' which is described by the Alcoholics Anonymous group as 'God as we understand Him.'

This concept is important for the social worker to grasp. It is not a creed to which the members are asked to adhere; there is no theological description of the Deity. Rather there is the admonition to the new member that if he would remain sober he must develop some concept of God which will be good enough for him to rely on to enable him to break the grip of the alcoholic obsession that is destroying his life.

The concepts of God with which members work are sometimes very crude and slightly shocking. They are very disturbing sometimes, to ministers and representatives of organized religion; but as the members mature in AA, their concepts tend to become more conventional, and many relate themselves firmly to a church.

The needs outlined above are largely met as the members struggle to live by what they call the program of 'Twelve Suggested

Steps' to recovery. Social workers will be interested in reading these steps to detect the spiritual and psychological principles upon which they rest. At this point a word of warning may be helpful for the worker. If he cannot accept the validity of a belief in a higher power as a source of strength for an individual's life, he must not try to work with Alcoholics Anonymous. It is not necessary for him to be a believer himself, but he must be willing to recognize that those who believe do find this strength and direction for their lives.

Working With an AA Group

No one can really understand the AA program by merely reading about it. The social worker who is interested should inquire as to the location of an AA group and learn when it will have an open meeting he can attend. It is likely that he, as all others that come in contact with the group, will be stimulated, excited, and deeply moved by what he sees going on in the group.

The groups vary in their methods. As a general rule, a number at each AA meeting describe their alcoholic experiences. The closing speaker will, perhaps, attempt to sum up what the others have said, and frequently will discuss the twelve steps of which the recovery program is composed. There is always an offering—passing the hat, as it is called—and the money is used to pay for the coffee and doughnuts and perhaps a modest

rental on the meeting place; for literature to give to new members and outsiders who may be interested; and for support of the national headquarters in New York.

Any social worker who wants to get in touch with AA can consult the phone book. Alcoholics Anonymous is listed under this name in most of the larger communities in the country and many smaller ones. If it is not in the book, the local policeman may know where the groups meet; sometimes the judges know. If the worker cannot find out in his own community, he can write to Alcoholics Anonymous, P.O. Box 459, Grand Central Station Annex, New York 17, New York, for the location of the nearest group.

IT WOULD BE wise for the worker to acquaint himself with the working of AA groups near him before attempting to enlist their help in behalf of a specific client. If he could go to one or two groups, introduce himself to the members, search out the secretary and ask for a telephone reference which he could use, explaining his own work and desire to enlist AA's support, he would undoubtedly meet with a universally ready response.

As noted above, AA has only two purposes: to help its members stay sober and to help others achieve sobriety. In pursuit of the second purpose (normally called 'carrying the message'), AA members are eager to be called on for

what they speak of as 'twelfth-step work' — so-called because the twelfth step of the program describes this obligation to help others.

Once the contact has been established and a working arrangement developed, the social worker should always make sure that the client is willing to discuss his problem with a member of AA before asking AA to come in. Invariably the AA member, when approached for help, will ask if the other person wants to see him. It does not have to be any passionate desire or any great interest; a passive willingness to talk to a member of AA will be adequate. If it is possible, the social worker should arrange to introduce the AA member to the client, either bringing the member to the client's home or taking the client to the AA meeting or the AA person's home.

Referral is not good enough and should be avoided wherever possible—referral, that is, in the sense of merely sending somebody somewhere else. The alcoholic has had a long experience of being passed along from person to person, with each one apparently eager to be rid of him. Referral in this way will merely convince the alcoholic that the social worker is like all the rest. If, however, the worker says, 'I want to take you to the AA meeting,' or 'I'd like to bring a member of AA with me when I come to call on you tomorrow night,' the situation is completely reversed and the alcoholic is as-

sured at least of an interest deep enough to account for the social worker's trouble in providing the introduction.

The worker must make sure the alcoholic understands that he is not just being abandoned to AA, but that he (the worker) hopes to keep in touch with him and his family to help in any way possible. But he will tell the client that he believes that if he can utilize the services of AA, this will be the best possible thing for him in the months to come. The worker should avoid the impression of dropping his responsibility because AA has been brought into the picture.

The social worker may find that, while AA attracts the client, the latter falls away again. He must be prepared for this and be willing to try some other AA group. AA groups are not all alike. In some parts of the city they are so specialized that they do not have the general appeal that is necessary. A business or professional man, for example, will do better in a group composed of people of similar background than in a group made up solidly of workingmen. By the same token, a woman may feel terribly lonely in an AA group where she is the only woman, but will be happier in a group with other woman members. AA groups themselves will be helpful in matching up their people with the client.

Occasionally, the social worker may get a refusal from AA. When the name of the client is men-

tioned, the AA spokesman may say that this man is well known to them and they do not believe that he has much interest. The social worker must not be disturbed by this, but may say that he was not aware of it and will talk to his client further. Perhaps the client will admit that he has been exposed to AA before and that it has not seemed to work. If he is willing to try again, AA is usually willing to take another chance with him.

FOR ALL social workers who wish to help alcoholics, the fellowship of Alcoholics Anonymous provides one of the most effective sources of assistance. All that is necessary is acceptance of the concept of alcoholics as sick people and a recognition that they can be helped, that none of them is hopeless, that each is a completely unique individual whose alcoholism has roots which may never be apparent, but whose

drinking must be stopped if his life is to be saved; that Alcoholics Anonymous, while not necessarily able to help every person, is able to help a great majority of alcoholics, and that its members stand ready and willing to assist if called upon and enabled to function in their own ways.

Social workers must be prepared to see members of AA violate many techniques and procedures that seem to them almost sacred. If they are wise, however, they will let the AA men and women work at their own tempo and in their own ways, for while they are not very strong on theory, they have worked out excellent pragmatic methods of helping alcoholics. The writer can assure any social worker who avails himself of the support and help of Alcoholics Anonymous of a fascinating experience and a deeply rewarding one. If he has a faith, he will find it deepened. If he has none, he will find his curiosity aroused.

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A New Drug In The Treatment Of Alcohol Withdrawal

Treatment of the acutely intoxicated patient or the one experiencing gross hangover symptoms has always presented especially difficult problems. In the first case the person behaves as though temporarily psychotic, sometimes offering prodigious resistance. In the hangover state, the curative sleeping and eating which will restore him to health are the very activities that he finds almost impossible to perform. Paraldehyde, barbiturates, and other sedative drugs have been the standard medication in recent years, but each has its own limitations, besides being potentially addictive.

Between May and October of 1960, a study was conducted at Blue Hills Hospital (Hartford, Conn.) with a new and nonaddictive drug, methamino-diazepoxide (trade-named Librium). The results were so good with the first 25 patients that the drug was adopted as the basic medication at this in-patient facility in the management of uncomplicated alcohol withdrawal. According to the report of J. E. Rosenfeld and D. H. Bizzaco, the earlier drugs are now prescribed only for unresponsive or senile patients.

At the start of the experiment, 50 mg. of methamino-diazepoxide were given intravenously to patients on admission, repeated if necessary after 3 hours and again 6 hours later. Thereafter the drug was given by mouth in gradually diminishing quantities until a maintenance dose was established. On this schedule, however, most patients slept only an hour at most. The initial dose was therefore increased to 75 mg. and later to 100 mg. 'At this level patients routinely fell asleep for 2 to 3 hours, could be aroused to take liquids if necessary, awoke refreshed with good appetite, and expressed surprising comfort.' No other medication was required or even requested. The total dose was kept at 150 mg. for the first 24 hours, after which patients were ready to participate in the hospital program.

Side effects of the drug were minimal. Ankle edema occurred in four cases, but was eliminated by lower dosage. Similarly the drowsiness and weakness which sometimes accompanied the large initial doses disappeared on the maintenance dosage.

After this preliminary test, a double-blind study with methamino-diazepoxide and placebos was

conducted. Each of 30 alcoholic patients received 100 mg. of the drug intravenously, repeated once or twice if indicated. Thereafter they were given capsules of 50 mg. or less until effective results were achieved. In 22 of these 30, compared to 8 of 30 controls given an inactive placebo by identical procedures, marked or moderate improvement was seen within 5 days. The placebo-treated also had to remain in the hospital much longer than those given the drug.

Rosenfeld and Bizzaco concluded that methamino-diazepoxide 'can be used in the general hospital to produce quiet and cooperative alcoholic patients. It does not seem to shorten the period of delusions and hallucinations, but it calms the patients markedly, diminishes anxiety and restlessness, enormously minimizes the need for restraints and deep sedation, and virtually eliminates the need for routine intravenous fluids in psychotic episodes.' Treatment can even be carried out in the patient's home, provided that delirium or hallucinosis does not impend.

At the District of Columbia General Hospital, methamino-diazepoxide 'is presently the drug of choice' in treating the acute states of alcoholism, according to J. D. Schultz. In the first 24 hours after admission, routine medication consists of intramuscular injection of 50 to 100 mg. of this drug, repeated two to four times, depending on the degree of motor excitement. This

regimen is continued on the second day or longer if necessary, followed by doses of 50 mg. four times daily by mouth until the toxic state is relieved. No other drugs are required except for bedtime sedation, when chloral hydrate (1 to 2 g.) is given.

In outlining the advantages of methamino - diazepoxide, Schultz notes, first, that it obviates the need for intravenous fluids; the patient can soon take liquids by mouth. Second, it is a more effective muscle relaxant than earlier preparations and, in addition, produces less hypotension. Third, it eliminates the need for restraints or the 'strong room.' Fourth, the acute toxic state is often relieved in 24 hours, after which the temperature is normal, the sensorium clear, and the patient is freely taking nourishment and fluids in the hospital dining room.

Another trial of methamino-diazepoxide is reported by M. D. Kissen (Saul Clinic, St. Luke's Hospital, Philadelphia). In a study of 80 alcoholic patients, consecutive admissions to the clinic, half received this drug in addition to the regular treatment regimen and the other half served as controls. Routine therapy included intravenous glucose in saline; the controls received either placebos, barbiturates, or other tranquilizers. The patients treated with methamino-diazepoxide were given 100 mg. on admission either intravenously, intramuscularly, or by mouth, then 10 mg. by mouth four times daily

for the remainder of their hospital stay. Symptoms of psychomotor agitation were rated at 8-hour intervals and patients with complications were eliminated from both groups before the scores were totaled.

Kissen reports that the patients treated with methamino-diazepoxide arrived at the optimum response level much sooner than the controls. With respect to sleep, appearance, appetite, tremor, depression and nervousness, 54 percent of the subjects but only one control patient had reached this optimum level within 40 hours. Even as early as 8 hours after admission, the two groups were showing marked differences in their degree of disablement.

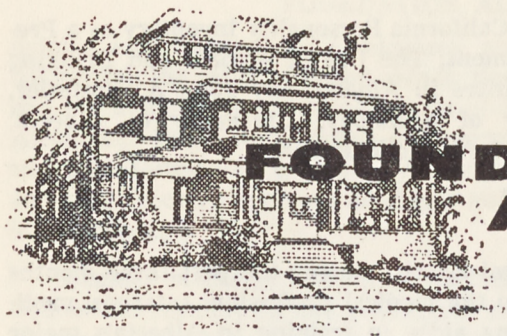
At the Central Indiana Alcoholism Clinic, the effectiveness of methamino-diazepoxide was evaluated in 175 patients experiencing alcohol withdrawal symptoms varying from mild tremulousness to delirium tremens and acute hallucinosis. This group, as described by F. E. Lawrence, also showed considerably more socioeconomic deterioration than the average; for example, few were employed, few married. The results confirmed the favorable reports from other

sources. 'Within a few minutes after adequate parenteral doses, or within half an hour to an hour after oral medication, even severely agitated patients showed quite marked relief of their symptoms and were then able to cooperate in their treatment . . . Furthermore, no patient in our series to date has experienced convulsions once treatment with (this drug) was instituted.'

Lawrence also reports that 'a significantly greater number of patients whose withdrawal symptoms were treated with this drug remained in continuing therapy, compared with any prior treatment method.' Since permanent rehabilitation of the alcoholic depends upon relatively long-term therapeutic relationships, this suggested effect of methamino-diazepoxide, if confirmed by subsequent research, could prove to have immeasurable value.

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FOUNDATION ACTIVITIES

Red Deer Consultation Clinic Opened

Acting on the findings of the Red Deer Community Advisory Committee on Alcoholism, formed in November, 1961, the Foundation, in cooperation with the Red Deer Municipal Hospital, undertook to open a treatment centre there in June. Mrs. Harland Irvine, an experienced social worker and wife of Red Deer's director of city welfare, was appointed to operate the new unit.

Staff

Miss Norma Howard has joined the Edmonton Clinic and Mr. Gordon H. Bird and Miss Mary Ann Flaherty the Calgary Clinic as counsellors.

Mr. R. W. Ramsay, a post-graduate student, and Mr. O. I. Porayko, a fourth year medical student at the University of Alberta, are working for the Foundation this summer in treatment and research.

The Foundation's staff development program moved ahead with the participation of two Information Officers and a Research Associate in special courses at New York's Columbia University and at the University of Toronto respectively. Three of the treatment staff attended the Canadian Conference on Social Work in Winnipeg.

RESEARCH ACTIVITIES

January-March, 1962

The following sub-studies were completed during the quarter:

Geographic Distribution of Case Status Patients; A Pilot Study of Problem Drinking Among University Hospital Out-Patient Department Admissions; Sex Ratios for Cirrhosis Deaths and Alcoholism; Geographical Distribution of Problem Drinking; Age Began Drinking, Edmonton and Calgary Intake, 1960-61; Female Intake, Inception -1955 Compared to 1958-1959, Edmonton Centre; Recovery Trends, Edmonton and Calgary, All Cases.

The following studies are currently underway:

Location and Identification of Alcoholics in a Small Community; Follow-up Study of Male Alcoholic Patients; Social Perception of

Female Alcoholic Patients; California Personality Inventory as a Prediction of Success in Treatment; The Use of Alcohol and Drinking Patterns Among the Hutterites in Alberta (By John A. Hostetler, Ph.D., Assistant Professor of Sociology, University of Alberta, Edmonton.); Self-concept of Alcoholic Patients.

EDUCATION ACTIVITIES

April-June, 1962

The Foundation's educational activity during the past three months continued to focus on service to the medical profession. Internes, medical students, nurses and nursing aides in training in Alberta's major cities, and in the nurses' training schools in Lamont, Vegreville, Lethbridge, and Ponoka, received an intensive series of orientation and instructional lectures.

A new development of considerable significance has been the introduction—and acceptance—of suggested alcoholism policy and administrative procedures to the executive of a publicly owned major Alberta utility. It is anticipated that the implementation of the program will establish an important precedent among Alberta's larger industrial and service organizations, and may add materially to the scope and effectiveness of the Foundation's work in secondary (and to some extent in primary) prevention of alcoholism in the province.

The incidence of success in the treatment and rehabilitation of alcoholics in U.S. industry has been outstanding. An employer's economic authority provides an unique opportunity in the field of alcoholism treatment. For example, one large organization with an effective and efficient referral and treatment program reports a success ratio of 83 per cent.

It is becoming more and more widely recognized that industrial alcoholism programs make good sense, both as a social and economic practice. Besides the preservation and rehabilitation of human and social values, industrial alcoholism treatment programs reduce direct dollar losses and so help to reduce production costs.

A skilled efficient and productive industrial worker represents a sizeable investment to his employer. Any impairment of his efficiency and productivity cuts net profits. To rehabilitate an alcoholic employee costs little more than an investment in time. It is most gratifying that North American industry, which invests hundreds of millions of dollars annually in mechanical repairs and retooling, is now recognizing the vastly more important value of its human assets.

The design, standardization and production of multiple sets of updated visual aids for Foundation lecturers was completed after several

months' effort in analysis, comparison, and modification. Long experience has proven the value of visual aids in the Foundation's educational work, and the availability of complete sets of identical charts to all provincial Alcoholism Foundation centres will contribute to both instructional work and a uniformity of approach. A portable and versatile easel was also designed to carry each set of charts and to facilitate their display during lectures.

Regular meetings with the Foundation's Edmonton Youth Advisory Committee resulted in the production and publication of a concise and informative booklet: *Looking at Alcohol*. This publication provides a useful discussion guide for high school students and young adults along those lines especially indicated in their approach to questions pertaining to drinking generally. The members of Edmonton's Teen Council organizations who participated in this work deserve full credit for a job well done.

April, May and June were busy months for the southern Alberta division of the Foundation. Orientation talks were given to the Calgary Society of X-Ray Technicians, the Calgary Labor Council and to numerous church groups, including several affiliated youth organizations. The Calgary Foundation's Medical and Treatment staff presented a series of four lectures to internes at the Calgary General Hospital. Members of the Calgary Police Recruit School also received an intensive instructional session on alcohol and alcoholism.

A full day seminar, arranged for the Calgary Council of Community Services, involved the participation of the majority of Calgary Foundation staff members. This was followed by an evening panel discussion and workshop.

Similarly, Lethbridge and Medicine Hat reports indicate a large volume of instructional talks given to various church groups, including men's and women's organizations. An impressive number of Catholic and United Church youth club members participated also.

TREATMENT ACTIVITIES

January-March, 1962

During the first quarter of 1962 intake was very high at the Foundation clinics at Edmonton, Calgary, Lethbridge, Medicine Hat, Grande Prairie, and Westlock. A total of 232 new and re-activated patients were seen. Attendance at the evening therapy groups held at both Edmonton and Calgary was at an all time high. Late in March, day groups for beginning patients were begun at the Edmonton Clinic. The group meetings at Lacombe continue to be well attended.

Ninth Annual Meeting

Mr. Murray E. Stewart was elected President of The Alcoholism Foundation of Alberta, succeeding Mr. D. S. Macdonald, at the annual meeting held in Edmonton on April 30th, 1962.

Mr. Stewart is a graduate of Strathcona High in Edmonton. He holds a B.Sc. from the University of Alberta and a M.Com. from the University of Toronto. He has been general manager of Northwestern Utilities since 1956. He is active in community affairs being a member of the board for organizations such as the Chamber of Commerce, United Fund, Council of Community Services, and many others.

Other officers elected by Foundation members were: Mr. G. L. Crawford and Mr. R. W. Burns, Vice-Presidents; Mrs. C. R. Wood, Honorary Secretary; Mr. J. S. McGuckin, Honorary Treasurer; Hon. Dr. J. Donovan Ross, Honorary Board Chairman.

The board of directors also includes: Mr. S. A. Keays, Mr. Wm. Newbigging, Dr. Walter C. McKenzie, Mr. C. W. Ross, Hon. Chief Justice S. Bruce Smith, Hon. Norman A. Willmore, Mr. E. W. Christian, all of Edmonton; Mr. George Cristall, Mr. J. B. Cross, and Dr. S. Thorson, Calgary; Dr. R. M. Parsons, Red Deer; Mr. George Russell, Medicine Hat; Magistrate R. E. Baynes, Grande Prairie; the Hon. E. C. Manning, Honorary Board Member.



Shown in the photograph are: seated; Mr. J. George Strachan, Executive Director; Mr. Murray E. Stewart, President; Mrs. C. R. Wood, Honorary Secretary; Mr. S. A. Keays, Board Member; standing: Mr. J. S. McGuckin, Honorary Treasurer; Hon. Dr. J. Donovan Ross, Honorary Board Chairman; Mr. R. W. Burns, Vice-President; Mr. D. S. Macdonald, Past President.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**

Professional advice and assistance on the problems of alcoholism.

- **AUDIO-VISUAL AIDS:**

Films, tapes, records, and displays are available on loan.

- **CONFERENCES and SEMINARS:**

To create a better understanding of the problems of alcoholism and methods of dealing with those problems.

- **INDUSTRIAL WORKSHOPS:**

For the education of management, supervisory staffs, and general employees in Alberta industry.

- **ORIENTATION PROGRAMS:**

For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups.

- **PUBLICATIONS:**

Progress, Digest on Alcohol Studies, and original brochures and pamphlets.

- **REFERENCE LIBRARY:**

Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine



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